

# Summary of Benefits Report for Hawaii, Medicaid

## InsureKidsNow.gov

### Preventive Services

|   | Is the service Covered? | Frequency         | List any service - specific limitations |
|---|-------------------------|-------------------|---|
| <b>Cleanings</b>  | Yes                     | 2 x year          |   |
| <b>Fluoride treatments (including fluoride varnishes)</b> | Yes                     | 2 x year          | BIRTH THROUGH AGE 20                    |
| <b>Sealants (list any tooth-specific limits)</b>          | Yes                     | 1 x every 5 years | 1ST AND 2ND MOLARS; AGES 5 THROUGH 20   |
| <b>Space maintainers</b>                                  | Yes                     |                   |   |

### Diagnostic Services

|  | Is the service Covered? | Frequency         | List any service - specific limitations | Recommended age of first visit ? |
|--|-------------------------|-------------------|---|----------------------------------|
| <b>Oral health screening or assessment</b> | No                      |                   |   |                                  |
| <b>Dental examinations</b>                 | Yes                     | 2 x year          |   | AGE 1                            |
| <b>Assessment of risk for tooth decay</b>  | No                      |                   |   |                                  |
| <b>X-Rays</b>                              |                         |                   |   |                                  |
| Bitewing                                   | Yes                     | 2 x year          |   |                                  |
| Full Mouth                                 | Yes                     | 1 x every 5 years |   |                                  |
| Panoramic                                  | Yes                     | 1 x every 2 years |   |                                  |

### Treatment Services

|   | Is the service Covered?             | Frequency | List any service - specific limitations          | Criteria for coverage |
|---|-------------------------------------|-----------|--|-----------------------|
| <b>Anti-microbial treatments that stop decay from spreading</b> | No                                  |           |  |                       |
| <b>Fillings</b>   |                                     |           |  |                       |
| Silver amalgam  | Yes                                 |           |  |                       |
| Tooth colored composite   | Yes                                 |           |  |                       |
| <b>Crowns/tooth caps</b>  |                                     |           |  |                       |
| Stainless steel crowns  | Yes                                 |           | IF PERMANENT TOOTH, PRIOR AUTHORIZATION REQUIRED |                       |
| Metal (only) crowns   | Yes - only with prior authorization |           | TEETH 2 THRU 15 AND 18 THRU 31                   |                       |
| Metal/porcelain crowns  | Yes - only with prior authorization |           | TEETH 2 THRU 15 AND 18 THRU 31                   |                       |
| Porcelain (only) crowns   | No                                  |           |  |                       |
| <b>Root Canals (endodontics)</b>                                |                                     |           |  |                       |
| Root canals on baby teeth (pulpotomies)                         | Yes                                 |           | ONLY PRIMARY TEETH                               |                       |
| Root canals on permanent teeth                                  | Yes                                 |           | TEETH 2 THRU 15 AND 18 THRU 31                   |                       |
| <b>Gum (periodontal) therapy</b>                                | Yes - only with prior authorization |           |  |                       |
| <b>Dentures</b>   |                                     |           |  |                       |
| Partial dentures  | Yes - only with prior authorization |           |  |                       |

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| Treatment Services                                   |                                     |           |   |   |
|--|-------------------------------------|-----------|---|---|
|  | Is the service Covered?             | Frequency | List any service - specific limitations                                   | Criteria for coverage   |
| Complete dentures                                    | Yes - only with prior authorization |           |   |   |
| Bridges  | No                                  |           |   |   |
| <b>Orthodontics*</b>                                 |                                     |           |   |   |
| Retainers (orthodontic)                              | Yes - only with prior authorization |           |   |   |
| Braces   | Yes - only with prior authorization |           |   | CLEFT PALATE OR OTHER SEVERE FACIAL BIRTH DEFECTS OR INJURY FOR WHICH SPEECH, SWALLOWING OR CHEWING IS RESTORED |
| <b>Oral surgery</b>                                  |                                     |           |   |   |
| Simple extractions                                   | Yes                                 |           |   |   |
| Surgical extractions                                 | Yes                                 |           |   |   |
| Care of abscesses                                    | Yes                                 |           |   |   |
| Cleft palate treatment                               | Yes - only with prior authorization |           |   |   |
| Cancer treatment                                     | No                                  |           |   |   |
| Treatment of fractures                               | No                                  |           |   |   |
| Biopsies   | Yes                                 |           |   |   |
| <b>Treatment of jaw joint problems (TMJ)</b>         | No                                  |           |   |   |
| <b>Emergency room services provided by a dentist</b> | Yes                                 |           |   |   |
| <b>Inpatient Hospital Services</b>                   | Yes                                 |           | PRIOR AUTHORIZATION AS REQUIRED BY THE SPECIFIC PROCEDURE BEING PERFORMED | ONLY SERVICES COVERED BY THE PLAN AND PERFORMED BY A DENTIST  |
| <b>Anesthesia</b>                                    |                                     |           |   |   |
| General anesthesia                                   | No                                  |           |   |   |
| Intravenous conscious sedation                       | Yes                                 |           |   | PROCEDURE CANNOT SAFELY BE PERFORMED W/O SEDATION   |
| Non-intravenous conscious sedation                   | No                                  |           |   |   |
| Analgesia (nitrous oxide)                            | Yes                                 |           | UNDER AGE 13  |   |

\* When this information is posted on the Insure Kids Now website, we will include a special note for orthodontic services explaining that parents and caretakers should work with their child's orthodontist to ensure that the treatment and payment terms and conditions are clear at the outset of treatment (for example, what happens in the case of a child who becomes ineligible for Medicaid or CHIP while he or she is undergoing orthodontic treatment?).